

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2092

CERTIFICATE OF DEATH

Reg. Dist. No.

02080

1. PLACE OF DEATH a. COUNTY Howard Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage		c. LENGTH OF STAY IN 1b 30 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage		d. STREET ADDRESS Commercial St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Emory C. Condon	Middle	Last	4. DATE OF DEATH Feb. 1 - 1960	Month	Day	Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1884		9. AGE (In years from birthday) 75 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Cotton Mill		11. BIRTHPLACE (State or foreign country) Carroll Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Edward F. Condon				14. MOTHER'S MAIDEN NAME Sarah J. West					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-01-7668		17. INFORMANT James H. Condon, Savage, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Multiple Asthmatic attacks		INTERVAL BETWEEN ONSET AND DEATH 5 days					
DUE TO Ch. asthma						3 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Ch. Myocardial Insuff.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) th		20f. (City or town) Feb. 1st		(County)	(State)
21. I certify that I attended the deceased from Jan. 27, 1960 , to Feb. 1st, 1960 , that I last saw the deceased alive on Feb. 1st, 1960 , and that death occurred at 3 P.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Savage, Md.	
ACTUAL SIGNATURE Frank E. Shipley		M.D.						DATE SIGNED	
PHYSICIAN'S NAME (Type) Frank E. Shipley									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 4, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Savage Cemetery		22d. LOCATION (City, town, or county) Savage, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Danaldean, Laurel, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

101 - CERTIFICATE OF DESIGN

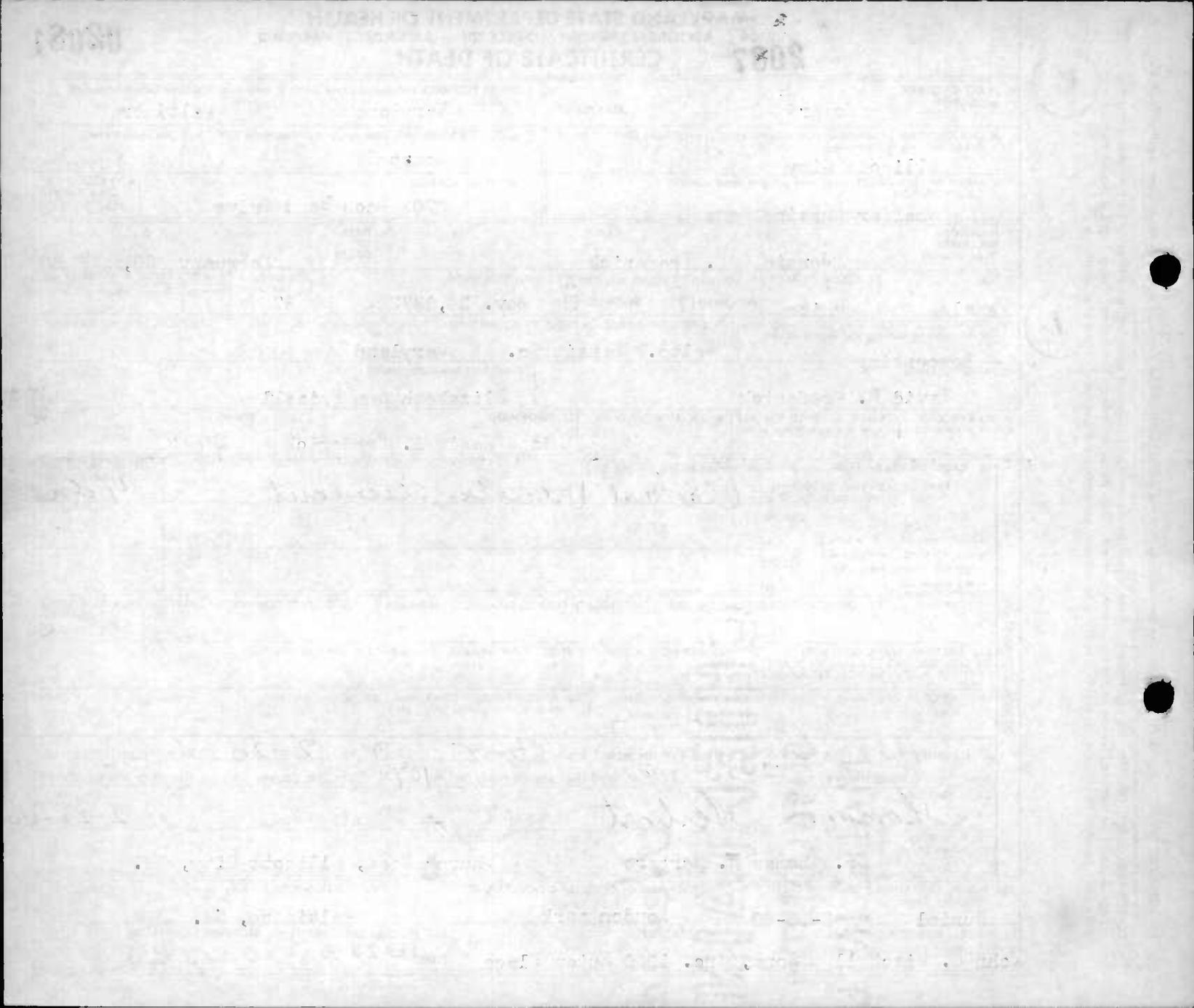
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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2087 CERTIFICATE OF DEATH

02081

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffer Nursing Home		d. STREET ADDRESS 8703 Loch Bend Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Jennie	Middle H. Frederick	Last Month Day Year February 20 19 60
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accounting		10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David H. Frederick		14. MOTHER'S MAIDEN NAME Elizabeth Ann Frizell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 331X		16. SOCIAL SECURITY NO. Miss Bessie A. Frederick	
17. INFORMANT Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 4 da	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-8 19 60 to 2-20 19 60, that (I) (we) last saw the deceased alive on 2-20 19 60, and that death occurred on 2-20 19 60, from the causes and on the date stated above.		22a. SIGNATURE Thomas F. Herbert	
22c. PHYSICIAN'S NAME (Type) Dr. Thomas F. Herbert		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Church Road, Ellicott City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-23-60	
23c. NAME OF CEMETERY OR CREMATORIALoudon Park		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place		25a. REC'D BY REGISTRAR DATE FEB 23 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2094

CERTIFICATE OF DEATH

Reg. Dist. No.

02082

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First ROSELIN	Middle 	Last HARDING	4. DATE OF DEATH	Month Feb.	Day 6,	Year 1960	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Aug. 10, 1959	9. AGE (In years lost birthday) yrs. 5 Months 26 Days	IF UNDER 1 YEAR 5	IF UNDER 24 HRS. 26	Hours 	Min. 	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland (Baltimore)		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas Harding			14. MOTHER'S MAIDEN NAME Hilda Carroll Coleman						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Thomas Harding Jessup, Md. Box 179		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 096.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO 									
Acute Virus infection Dehydration INTERVAL BETWEEN ONSET AND DEATH 5 days 3 days									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Doy 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) 	(County)	(State)	
21. I certify that I attended the deceased from 9/26 , 19 59 to 2/6 , 19 60 at I last saw the deceased alive on 2/6 , 19 60 , and that death occurred at M , from the causes and on the date stated above. ACTUAL SIGNATURE J. M. Warren M.D.									
ADDRESS (Street, city or town, state) 									
PHYSICIAN'S NAME (Type) 									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/60		22c. NAME OF CEMETERY OR CREMATORIAL Guilford Baptist.,		22d. LOCATION (City, town, or county) Jessup, Md.			
(State)									
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Strode, M.A.		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE FEB 10 '60		24b. REGISTRAR'S SIGNATURE C. J. Evans			
VS A15 (4) 15M 9/54									

81. PERSONS WITH HEADACHE—STATE QUADRANT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2093

CERTIFICATE OF DEATH

02083

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Howard</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>Maryland</i>		b. COUNTY <i>Howard</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Savage</i>		c. LENGTH OF STAY IN 1b <i>34 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Savage</i>		d. STREET ADDRESS <i>1 Guilford Rd.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Guilford Road</i>				d. STREET ADDRESS <i>1 Guilford Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>CHARLES</i>		First <i>L.</i>	Middle <i>HEISHMAN</i>	last <i></i>	4. DATE OF DEATH <i>February 12 1960</i>	Month <i></i>	Day <i></i>	Year <i></i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 22, 1908</i>	9. AGE (In years last birthday) <i>51 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>		11. IF UNDER 24 HRS. Days <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Helper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>OS</i>		11. BIRTHPLACE (State or foreign country) <i>Edinburgh, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>James M. Heishman</i>		14. MOTHER'S MAIDEN NAME <i>Ada Laura Litten</i>		Address <i></i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>28-26-2007</i>		17. INFORMANT <i>Mrs Elma Heishman, Savage Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cirrhosis Liver</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
DUE TO <i>260X</i>		(b) <i>Atherosclerosis</i>		(c) <i>Carcinoma site unknown</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last <i></i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerosis</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>8/23 1944</i> to <i>2/12 1960</i> , that I last saw the deceased alive on <i>2/2 1960</i> , and that death occurred at <i>6140</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. M. Warren</i>						ADDRESS (Street, city or town, state) <i></i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/15/60</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Savage Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Savage Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Donaldson, Laurel, Md</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR DATE FEB 19 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hayes</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

5003

10-19-02

NAME OF DECEASED	
JAMES A. HEAD	
ADDRESS	
1000 E. 36TH ST. BALTIMORE, MD 21218	
CITY, STATE, ZIP	
BIRTH DATE	
10-19-1918	
DEATH DATE	
10-19-2002	
AGE AT DEATH	
84	
SEX	
MALE	
CAUSE OF DEATH	
HEART DISEASE	
METHOD OF DEATH	
NATURAL	
TIME OF DEATH	
10:00 AM	
TIME OF CERTIFICATION	
10:30 AM	
SIGNATURE	
SARAH M. HARRIS MD, FACP Physician	
STAMP	
MD DEPT. OF HEALTH & MENTAL HYGIENE 100 W. ST. PETERSBURG, BALTIMORE, MD 21201 (301) 577-1000	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2088

CERTIFICATE OF DEATH

02084

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Indiana b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	c. LENGTH OF STAY IN lb 12 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Michigan City 52 X-3				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Sadie	Middle	Last Hirsch			
4. DATE OF DEATH February 29	Month	Day	Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov 7, 1899	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Indiana	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Ignatz Kline		14. MOTHER'S MAIDEN NAME unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT hospital record Taylor Manor Hosp Ellicott	Address City, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X		Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)				
		INTERVAL BETWEEN ONSET AND DEATH 1 week				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Schizophrenia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Taylor Manor Hospital	(County)	(State)
21. I certify that I attended the deceased from Apr 27, 1957, to Feb 29, 1960, that I last saw the deceased alive on Feb 29, 19 60, and that death occurred at 8 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Irving J. Taylor M.D. 2/29/60						
PHYSICIAN'S NAME (Type) Irving J. Taylor, M.D.		Taylor Manor Hospital, Ellicott City, Md				
22a. BURIAL, CREMATION, REMAINS (Specify) burial		22b. DATE THEREOF 3/3/60	22c. NAME OF CEMETERY OR CREMATORIUM greenwood	22d. LOCATION (City, town, or county) Michigan City, Ind	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham		ADDRESS Ellicott City, Md.	24a. REC'D BY REGISTRAR DATE MAR 3 '60	24b. REGISTRAR'S SIGNATURE Irving S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2095 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02085

TO DEPUTY MEDICAL EXAMINER: his certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodstock		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville , 28	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cavey Lane		d. STREET ADDRESS 2202 Rock Haven Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Charles	Middle Henry	Last Hoke	4. DATE OF DEATH Month Feb. Day 7 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	b. DATE OF BIRTH 4/17/1893	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit		11. BIRTHPLACE (State or foreign country) Klingerstown, Pa	
13. FATHER'S NAME William Hoke		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-05-9440		17. INFORMANT Address Mrs. Clara M. Hoke, Catonsville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH - 10 min. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Vascular Disease 1 year (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>George E. Burgtoft</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2-6-60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-10-60		22c. NAME OF CEMETERY OR CREMATORIAL Lakeview	
22d. LOCATION (City, town, or county) Pt. 26 Baltimore County, Md				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham		ADDRESS Ellicott City Md		24a. REC'D BY REGISTRAR DATE FEB 9 '60	
				24b. REGISTRAR'S SIGNATURE <i>Arthur J. Tamm</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2096

02086

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Howard</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Marriottsville</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Marriottsville</i>	
3. NAME OF DECEASED (Type or print) <i>JAMES EMORY JOHNSON</i>		First <i></i>	Middle <i></i>
		Last <i></i>	4. DATE OF DEATH <i>Feb. 14 1960</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 10 1879</i>
9. AGE (In years last birthday) <i>80 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardener</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Garden</i>	12. BIRTHPLACE (State or foreign country) <i>Md.</i>
13. FATHER'S NAME <i>James Johnson</i>	14. MOTHER'S MAIDEN NAME <i>Lucy Davis</i>	15. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	17. SOCIAL SECURITY NO. <i></i>	18. INFORMANT <i></i>	Address <i></i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> Conditions, if any, which give rise to immediate cause (a), stating the underlying cause first. (b) DUE TO <i>cardiac failure, coronary thrombosis</i> (c) <i>edema - Arteriosclerosis generalized</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>1959 to 14 Feb 60</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1959</i> , 19, to <i>14 Feb</i> , 1960, that (I) (we) last saw the deceased alive on <i>14 Feb</i> , 1960, and that death occurred at <i>5 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Howard E. Hall</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>2/15/60</i>
22c. PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>		22d. ADDRESS <i>Arlowville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>2-17-60</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>West Liberty</i>	23d. LOCATION (City, town, or county) (State) <i>Albion, Howard Co. Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Father of Height</i>		ADDRESS <i>Arlowville, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>FEB 19 '60</i>
			25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

1 AUGUST 1970 5000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2097 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02087

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups		d. STREET ADDRESS Berger Road		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Berger Road						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ELLEN CATHERINE KAHLER		First	Middle	Last	4. DATE OF DEATH Feb. 10, 1960	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9-3-1899	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ednor, Md		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME John Coar			14. MOTHER'S MAIDEN NAME Mary Harding					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Adam Kahler, Jessups, Md		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation by hanging DUE TO 974X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Strangulation by hanging (self inflicted)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. 5 P.M. 2-10-60 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At Home		20f. (City or town) (County) (State) Jessups Howard Co Md		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>George E. Burgtoft</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2-12-60	
EXAMINER'S NAME (Type) George E. Burgtoft M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-13-60	22c. NAME OF CEMETERY OR CREMATORIUM St Pauls		22d. LOCATION (City, town, or county) Fulton, Md		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md			ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 15 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

STATE OF TEXAS
DEPARTMENT OF PUBLIC SAFETY

MOTOR VEHICLE EXAMINER'S CERTIFICATE OF DATA

SEARCHED

INDEXED

SERIALIZED

FILED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2089

CERTIFICATE OF DEATH

02088

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN lb 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital			d. STREET ADDRESS 2812 N. Loudon Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First William	Middle L	Last Mazaroff	4. DATE OF DEATH Feb. 16	Month Day Year Feb. 16 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb 13, 1890	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant- retired			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Russia		
13. FATHER'S NAME Abraham			14. MOTHER'S MAIDEN NAME Toba			12. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Det Mazaroff. Son	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 480 X DUE TO Pulmonary edema bilateral			INTERVAL BETWEEN ONSET AND DEATH 36 hrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Myocardial failure, rt. sided DUE TO (c) Influenza with broncho-pneumonia			72 hrs. 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Balto	(County)	(State)
21. I certify that I attended the deceased from Feb 10, 1960, to Feb 16, 1960, that I last saw the deceased alive on Feb 16, 1960, and that death occurred at 5 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Taylor Manor Hospital DATE SIGNED ACTUAL SIGNATURE Stephen Lee Magness, M.D. 2/16/60						
PHYSICIAN'S NAME (Type) Stephen Lee Magness, M.D. Taylor Manor Hosp. Ellicott City, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-17-60	22c. NAME OF CEMETERY OR CREMATORIUM United Hebrew	22d. LOCATION (City, town, or county) Balto		
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Jr. 2100 Elizab Place			ADDRESS	24a. REC'D BY REGISTRAR FEB 18 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Knob	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02089

2090

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 1 yr. 4 mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22	
3. NAME OF DECEASED (Type or print) George		f. STREET ADDRESS 3023 Dunglow Road	
4. DATE OF DEATH Feb. 15		Month Feb.	Day 15
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Dec 27, 1891		9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 0
11. BIRTHPLACE (State or foreign country) Baltimore County		12. IF UNDER 24 HRS. Days 0	Hours 0
13. FATHER'S NAME Jacob Norris		14. MOTHER'S MAIDEN NAME Elizabeth ?? (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-28-6986	
17. INFORMANT HOSPITAL RECORD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cerebral arteriosclerosis		unknown	
(c) Arteriosclerosis, generalized		unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome, associated with cerebral a.s. with psychosis		19. WAS AUTOPSY PERFORMED? No	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) psychosis	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 13 , 1958, to Feb 15 , 1960, that I last saw the deceased alive on Feb 15 , 1960, and that death occurred at 3:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Stephen Lee Magness		DATE SIGNED 2/15/60	
PHYSICIAN'S NAME (Type) Stephen Lee Magness, M.D.		Taylor Manor Hospital	
22a. BURIAL, CREMATION, REMAINS? (Specify) Burial		22b. DATE THEREOF 2/18/60	
22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery		22d. LOCATION (City, town, or county) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Jr.		24a. REC'D BY REGISTRAR ADDRESS Dundalk 22, Md. DATE FEB 17 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02090

2098

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <i>Howard</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooksville</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Brooksville</i>		d. STREET ADDRESS <i>Bushy Park Road</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WinFIELD		First S.	Middle PARKER
4. DATE OF DEATH Feb. 14 1960		Month	Day Year
5. SEX M	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1887
9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months —	11. IF UNDER 24 HRS. Days —	12. IF UNDER 24 HRS. Hours —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gabor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Garrison</i>	
10c. BIRTHPLACE (State or foreign country) <i>Md.</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry Parker</i>		14. MOTHER'S MAIDEN NAME <i>Mollie Gassaway</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> [Yes, no, or unknown]		16. SOCIAL SECURITY NO. —	
17. INFORMANT <i>Mrs Virginia Parker - Brooksville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X		INTERVAL BETWEEN ONSET AND DEATH From 600	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO Bronchial pneumonia, cardiac failure, coronary thrombosis, arteriosclerosis generalized.		1 + 7 ft 60	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 19 '60 to 14 Feb 19 '60 that (I) (we) last saw the deceased alive on 14 Feb 19 '60 and that death occurred at Md. from the causes and on the date stated above.		22b. DATE SIGNED 2/15/60	
22c. PHYSICIAN'S NAME (Type) HOWARD E. HALL		22d. ADDRESS Asheville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-18-60	
23c. NAME OF CEMETERY OR CEMATORIUM Bushy Park		23d. LOCATION (City, town, or county) (State) Brooksville, Howard, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kraus</i>		25a. REC'D BY REGISTRAR DATE FEB 19 '60	
ADDRESS Arthur S. Kraus		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

00050

REPORT OF THE
COMMISSIONER OF THE
GENERAL LAND OFFICE

REGARDING THE

2002

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2099

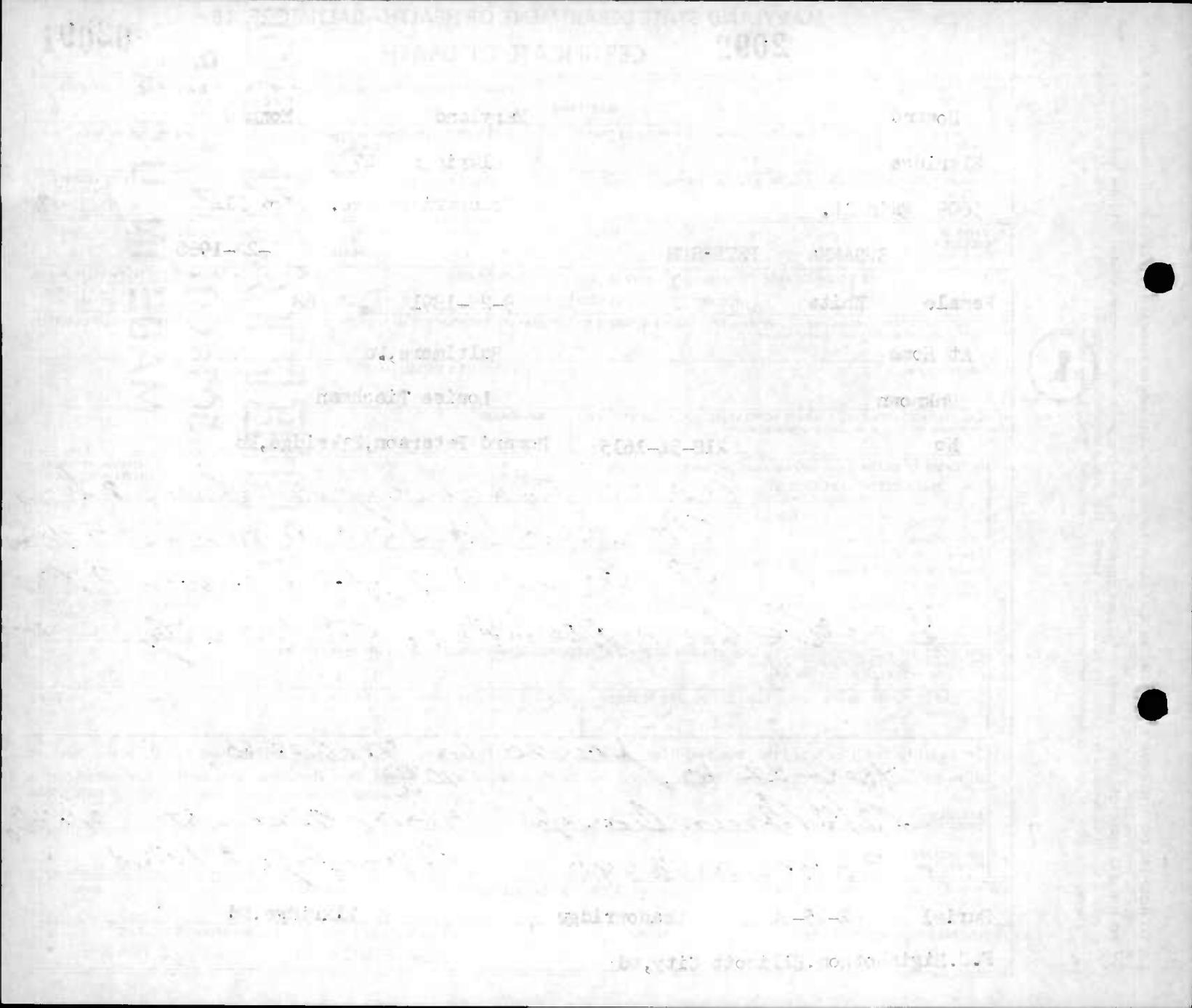
CERTIFICATE OF DEATH

Reg. Dist. No.

02091

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Howard	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	b. COUNTY Howard
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge 27	d. STREET ADDRESS Meadowridge Ave. Box 314
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5609 Main St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) SUSANNA PETERSON	First Middle Last	4. DATE OF DEATH 2-22-1960	Month Day Year 2 22 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-28-1891
9. AGE (In years last birthday) 68 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	11. BIRTHPLACE (State or foreign country) Baltimore, Md	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Louise Tiechman	INFORMANT Howard Peterson, Elkridge, Md	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 218-34-1615	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) acute Coronary occlusion 2 hrs			
DUE TO (c) Cardio Vascular Disease 5 yrs			
ARTERIAL HYPERTENSION 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
Diabetes mellitus, obesity			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fall from bed			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 20, 1960 to Feb 22, 1960 that I last saw the deceased alive on Feb 22, 1960 , and that death occurred at 10:20 AM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Elkridge, Md			
DATE SIGNED 3/2/60			
ACTUAL SIGNATURE B.B. Brumbaugh	PHYSICIAN'S NAME (Type) B.B. Brumbaugh	22d. LOCATION (City, town, or county) Elkridge, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-25-60	22c. NAME OF CEMETERY OR CREMATORIAL Meadowridge	(State)
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE FEB 25 '60	24b. REGISTRAR'S SIGNATURE Cirius S. Kraus



FOR STATE
HEALTH DEPT.

delay is necessary, please
call the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2091 CERTIFICATE OF DEATH

Reg. Dist. No.

02093

1. PLACE OF DEATH a. COUNTY Howard County		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffers Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Louise		First	Middle
		Last	WARNER
4. DATE OF DEATH FEB. 27, 1960		Month	Day
		Year	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1879
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank E. Schneider		14. MOTHER'S MAIDEN NAME Katherine Zeller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. John L. Warner 2434 Brambleton Road.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-27 , 19 53 , to 2-27 , 19 60 , that I last saw the deceased alive on 2-27 , 19 60 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 46 Church Road	
ACTUAL SIGNATURE Thomas F. Herbert		DATE SIGNED 2-27-60	
PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.		Ellicott City, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/2/60	
22c. NAME OF CEMETERY OR CREMATORIAL Druid Edge Cemetery		22d. LOCATION (City, town, or county) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.		24a. REC'D BY REGISTRAR MAR 2 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~please~~ carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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